STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155165	A. BUILDING 00 B. WING	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW VILLAGE	586 EASTERN BOULEVARD CLARKSVILLE, IN47129

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F0000	This visit was for Recertification and State Licensure Survey. Survey dates: October 3, 4, 5, 6, 7, 2011 Facility number: 000082 Provider number: 155165 AIM number: 100289640 Survey Team: Avona Connell, RN TC Donna Groan, RN Gloria Reisert, MSW Dorothy Navetta, RN Census bed type: SNF/NF : 111 Total: 111 Census payor type: Medicare: 17 Medicaid: 77 Other: 17 Total: 111 Sample: 23 Supplemental sample: 03 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this Plan of Correction does not constitue an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review on or after November 1, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Quality review completed on October 13, 2011 by Bev Faulkner, RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the physician/Hospice when a resident with a recent history of DVT [deep vein thrombosis - blood clots] complained of severe leg pain from groin to ankle. This deficient practice affected 1 of 23 residents reviewed for changes in	F0157	It is the practice of this provider to immediately inform the resident, consult, with the residents physician and if known notify the residents legal representative or interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention a	11/01/2011

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	condition in a sample of 23 residents. (Resident #33) Finding includes: Review of the clinical record for Resident #33 on 10/5/2011 at 12:07 p.m., indicated the resident was admitted to the facility on 11/18/2010 and subsequently re-admitted from the hospital on 9/11/2011. Diagnoses included, but were not limited to, DVT [deep vein thrombosis - blood clot], cancer of esophagus, lung and bronchus; metastatic neoplasm brain and spinal cord, diabetes mellitus, ischemic heart disease, and atrial fibrillation. Review of the nursing notes between 9/1/2011 and 10/5/2011 indicated the following entries: - "9/8/2011 at 2:20 a.m.: Resident complaint of LLE [left lower extremity] pain, after assessment edema +1 pitting noted, skin dry and warm to touch, pedal pulse week [sic] in LLE noted, complaint of pain in left thigh noted, called [name of nurse practitioner] new order to send to [hospital] for Doppler study [to check blood flow through veins]." - "9/11/2011 at 3:00 p.m.: readmitted to facility room [number] from [hospital]...denied pain, gait balance		significant change in the residents physical mental or psychosocial status; a need to alter treatement significantly; or a decision to transfer or discharge a resident from the facility.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?On 10/7/11 the charge nurse conducted a pain assessment of resident #33. The Physician and Hospice were consulted and new orders were received for adjustments in pain medications.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents receiving pain medication will be re-assessed to ensure the medications ordered are effective by 11/1/11. Physician /Hospice notification will occur if ineffective pain regiman is identified and appropriate medication adjustments will be made as indicated.Residents receiving pain medications will be monitored for effectiveness of the the medication. The Charge Nurse will monitor for effectiveness of pain medications every shift and document on MAR. If pain symptoms persist the MD/Hospice will be notified.3. What measures will be put into place or what systemic changes you will make to ensure that the	

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	stable..." New orders included: continue previous nursing home meds; Lovenox [injection given to thin the blood] 1 milligram [mg] SC [subcutaneous] every 12 hours; Coumadin [medication to thin the blood] 3.5 mg every day; PT/INR [prothrombin time/internationalized normalized ratio] every day until >/- [greater than or equal to] 2.5. Readmission diagnosis was DVT. - "9/13/2011 at 10:51 p.m.:...C/O [complains] mild pain in bilateral lower extremities. States 'I'll go to bed and I will feel better.' Left lower leg tight and edematous..." - "9/14/2011 at 9:01 p.m.:..."Bilateral lower extremities swollen and tight, cool and dry to touch...At times will admit that legs hurt..." - "9/16/2011 at 2:31 a.m.:...LLE +1 edema noted, cool to touch and swollen noted, pedal pulse weak on left leg..." - "9/27/2011 at 5:30 p.m.: Hospice notified of residents [sic] complaint of pain in his left lower extremity from groin to ankle. New order received for Hydrocodone/APAP 5/500 mg - 1 by mouth at 8 am and 5 pm everyday for pain..."		deficient practice doesn not reoccur?Physician(s)/Hospice will be notified if ineffective pain managment concerns are identified and appropriate medication adjustments are indicated.The licensed staff will be re-inserviced on or before 11/1/11 by the DNS or Designee on Change in Condition /Physician /Hospice Notification.Residents receiving pain medications will be monitored for effectiveness of the the medication. The Charge Nurse will monitor for effectiveness of pain medications every shift and document on MAR. If pain symptoms persist the MD/Hospice will be notified.4. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place?The DNS/Designee will complete the Change in Condition CQI tool weekly for 4 weeks and monthly for 6 months and report findings to the CQI Committee. The CQI committee will review the CQI tools and if thresholds of 90% are not met , action plans will be developed to improve performance and determine the need for further action.Non-Compliance with facility procedures may result in re-education and/or disciplinary action.	

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	- "9/27/2011 at 7:23 p.m.: C/O pain in left leg from groin to ankle..." - "9/29/2011 at 5:52 a.m.: Res. c/o severe pain to left lower ext [extremities]. Per report, res. c/o pain yesterday evening. Upon assessment res. noted with increased swelling and redness to left leg. Res stating 'Please send me to the hospital.' Call placed to [name of Hospice]. Notified of res. change in condition. Return call received from [Hospice]...Order received to send to [hospital] ER for eval and treat...Res. abed at this time, requesting frequently to go to hospital..." - "9/29/2011 at 6:00 a.m.:...Left leg remains red, swollen, tender..." - "9/29/2011 at 11:00 a.m.: Res returned from [hospital] with new orders received and noted..." New orders included: Lovenox 1.5 mg SQ daily until INR > 2.0 then D/C [discontinue]; change Coumadin to 4 mg daily; Daily INRs until INR > 2.0; D/C Lortab 5/500; Lortab 10/500 - 1 every 8 hours. - "9/29/2011 at 7:56 p.m.: DX [diagnosis]: DVT C/O severe pain left leg from groin to ankle. Denies pain in abdomen. receives Coumadin and			

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	Lovenox routinely. Coumadin orders change often R/T [related to] PT/INR results. Pain med increased without much effect. Continue to monitor and treat." Documentation was lacking of the physician or Hospice having been notified the resident was again experiencing severe pain as he had earlier that morning. During an interview with LPN #1 [Licensed Practical Nurse] and the DoN [Director of Nursing] on 10/6/2011 at 10/50 a.m., LPN #1 indicated she would have notified the physician of the pain medication not being effective and the leg pain, especially since that was why he went out that morning. On 10/6/2011 at 12:30 p.m., the DoN presented a copy of the facility's current policy on "Resident Change of Condition." Review of this policy included, but was not limited to: "Policy: It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs. Procedure:...2 Acute Medical Change: a. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental			

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	behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse will notify the physician...All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met..." 3.1-5(a)(3)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to assess and monitor a resident with multiple recent hospitalizations for DVT [deep vein thrombosis - blood clots] when he voiced frequent complaints of pain and the leg became reddened with swelling and edema. This deficient practice affected 1 of 1 resident reviewed for DVT in a sample of 23 residents. (Resident #33) Finding includes: Review of the clinical record for Resident #33 on 10/5/2011 at 12:07 p.m., indicated	F0309	It is the policy of this provider to provide the necessary care and services to attain or maintain the highest practicalbe physical, mental and psychosocial well being in accordance with the comprehensive assessment and careplan 1. What corrective action will be accomplished for those residetns found to have been affected by the deficient practice?On 10/7/11 A comprehensive assessment was conducted on Resident #33 to ensure the appropriate measures i.e., Measure lower left leg circumference daily to monitor for venous obstruction, Encourage to keep legs elevated while in bed to	11/01/2011

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	the resident was admitted to the facility on 11/18/2010 and subsequently re-admitted from the hospital on 9/11/2011. Diagnoses included, but were not limited to, DVT [deep vein thrombosis - blood clot], cancer of esophagus, lung and bronchus; metastatic neoplasm brain and spinal cord, diabetes mellitus, ischemic heart disease, and atrial fibrillation. Review of the nursing notes between 9/1/2011 and 10/5/2011 indicated the following entries: - "9/8/2011 at 2:20 a.m.: Resident complaint of LLE [left lower extremity] pain, after assessment edema +1 pitting noted, skin dry and warm to touch, pedal pulse week [sic] in LLE noted, complaint of pain in left thigh noted, called [name of nurse practitioner] new order to send to [hospital] for Doppler study [to check blood flow through veins]." - "9/11/2011 at 3:00 p.m.: readmitted to facility room [number] from [hospital]...denied pain, gait balance stable..." New orders included: continue previous nursing home meds; Lovenox [injection given to thin the blood] 1 milligram [mg] SC [subcutaneous] every 12 hours; Coumadin [medication to thin the blood] 3.5 mg every day; PT/INR [prothrombin time/internationalized normalized ratio]		decrease pain and edema each shift, monitor every shift for signs and symptoms of pulomary embolism; chest pain, SOA and apprehesion, support full length of the legs and ensure proper positions while in bed each shift. These measures are in place to monitor resident DVT. Physician and Hospice were notified of persistent symptions and medication adjustments were made. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?An audit was conducted of resident(s) diagnosis and no other residents were identified as having a active DVT. No other residents were be affected by this practice.3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice doesn not reoccur?The licensed staff were in-serviced on 11/01/11 by DNS/Designee on DVT Assessment, Monitoring and Documention of Pain Protocal. All residents receiving pain medication will be re-assessed to ensure the medications ordered are effective by 11/1/11. Residents receiving pain medications will be monitored for effectiveness of the the medication. The Charge Nurse will monitor for effectiveness of pain medications every shift and document on MAR. A pain	

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	every day until >/- [greater than or equal to] 2.5. Readmission diagnosis was DVT. - "9/13/2011 at 10:51 p.m.:...C/O [complains] mild pain in bilateral lower extremities. States 'I'll go to bed and I will feel better.' Left lower leg tight and edematous..." - "9/14/2011 at 9:01 p.m.:..."Bilateral lower extremities swollen and tight, cool and dry to touch...At times will admit that legs hurt..." - "9/16/2011 at 2:31 a.m.:...LLE +1 edema noted, cool to touch and swollen noted, pedal pulse weak on left leg..." - "9/27/2011 at 5:30 p.m.: Hospice notified of residents (sic) complaint of pain in his left lower extremity from groin to ankle. New order received for Hydrocodone/APAP 5/500 mg - 1 by mouth at 8 am and 5 pm everyday for pain..." - "9/27/2011 at 7:23 p.m.: C/O pain in left leg from groin to ankle..." - "9/29/2011 at 5:52 a.m.: Res. c/o severe pain to left lower ext [extremities]. Per report, res. c/o pain yesterday evening. Upon assessment res. noted with increased swelling and redness to left leg.		assessment will be conducted if pain symptoms persists and the MD and/or Hospice will be notified.4. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Change in Condition CQI tool weekly for 4 weeks and monthly for 6 months and report findings to the CQI Committee. The CQI committee will review the CQI tools and if thresholds of 90% is not met , action plans will be developed to improve performance and determine the need for further action.Non-Compliance with facility procedures may result in re-education and/or disciplinary action.	

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	Res stating 'Please send me to the hospital.' Call placed to [name of Hospice]. Notified of res. change in condition. Return call received from [Hospice]...Order received to send to [hospital] ER for eval and treat...Res. abed at this time, requesting frequently to go to hospital..." - "9/29/2011 at 6:00 a.m.:...Left leg remains red, swollen, tender..." - "9/29/2011 at 11:00 a.m.: Res returned from [hospital] with new orders received and noted..." New orders included: Lovenox 1.5 mg SQ daily until INR > 2.0 then D/C [discontinue]; change Coumadin to 4 mg daily; Daily INRs until INR > 2.0; D/C Lortab 5/500; Lortab 10/500 - 1 every 8 hours. - "9/29/2011 at 7:56 p.m.: DX [diagnosis]: DVT C/O severe pain left leg from groin to ankle. Denies pain in abdomen. receives Coumadin and Lovenox routinely. Coumadin orders change often R/T [related to] PT/INR results. Pain med increased without much effect. Continue to monitor and treat." The next nursing note regarding the resident's leg was on 9/30/2011 at 1:44 p.m. - 17 hours after the resident			

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	complained of severe pain in his left leg from groin to ankle, similar to what the resident had been sent to the hospital for earlier on 9/29/2011. Documentation was also lacking of an assessment of the resident's leg on 9/2/7/2011 at 7:23 p.m. and on 9/29/2011 at 7:56 p.m. During an interview with LPN #1 [Licensed Practical Nurse] and the DoN [Director of Nursing] on 10/6/2011 at 10:50 a.m., LPN #1 and the DoN indicated there should have been more descriptions of what the resident's leg looked like on those days along with more frequent documentation of what staff indicated they would be monitoring. Review of the Lippincott's Pocket Manual of Nursing Practice Second Addition listed monitoring to include, but was not limited to: measure and record the patient's leg circumferences daily to monitor for venous obstruction; elevate the patient's legs as directed for venous drainage, reduce swelling and relieve pain; supporting the full length of the legs and ensure proper patient positioning in bed; monitor for signs of pulmonary embolism, chest pain, dyspnea [shortness of breath] and apprehension."			

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F0323 SS=D	3.1-37(a) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure a resident with a history of falls received adequate supervision to prevent falls. This deficient practice had the potential to effect 1 of 5 residents reviewed for falls in a sample of 23. (Resident #076) Findings include: The clinical record for Resident #076 was reviewed on 10/05/2011 at 11 a.m. The resident's diagnoses included, but were not limited to Alzheimer's dementia and psychosis with behaviors. The resident was admitted to the facility on 02/14/2011 with a history of falls. The most recent MDS (Minimum Data Set) Quarterly Assessment, dated 07/20/2011, included, but was not limited to cognitive impairment- severely impaired. On 10/06/11 at 9 a.m., Resident #76 was observed seated in a geri-chair recliner with a personal alarm in the lounge area on the 2nd floor. The resident's eyes were	F0323	It is the practice of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.1. What corrective action will be accomlished for those residents found to have been affected by the deficient practice?The IDT reviewed on 10/19/11. The fall interventions were discussed and deemed appropriate. No changes were made to residents plan of care for falls. Resident has not experienced a fall from bed since 5/25/11. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents at risk for falls have the potiental to be affected by this practice.Current residents will be re-assessed for fall risk by 11/01/11.Those identified to be at risk for falls will be reviewed by the IDT. Careplans will be updated to include revisions if appropriate.3. What measures will be put into place or what	11/01/2011

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	closed and a TV was on. The Nursing Functional Independence Treatment Program CarePlan and Nurse Evaluation indicated the resident was placed on an individualized toilet program to "toilet q. (every) 2 hrs (hours). The Interdisciplinary Team Progress Notes included, but was not limited to: 2/15/2011 "IDT for fall review. Res had unwitnessed fall on 2/14/11 at 7:45 p.m. in hallway. MD notified at 8 p.m. with no new orders...8:05 pm. prior to fall res was sitting in w/c (wheelchair) in hall. Nurse went to answer call light, when she came back res. was lying on (R) (right) side with arm above head, full body assessment completed per nurse...Res unable to report what happened R/T (related to) dx (diagnosis) dementia after assessment res was assisted up per iii (3) staff. Intervention w/c/ bed alarm." 2/15/11 "IDT meeting and review R/T behaviors. Res. staying up all noc, requiring 1:1 attention R/T frequent attempts to get out of bed & w/c. Spoke with dtr & son-in-law this am. They voiced res. has always gotten up OOB (out of bed) q. 2 hours during the night to toilet & would go back to sleep after. Spoke with them about res. picking things out of the air & bending over in w/c		systemic changes you will make to ensure the deficient practice does not recur?Staff have been re-educated on the Falls/Fall Prevention Program on or before 11/01/11 by DNS or designee. Residents are assessed for fall risk upon admission/re-admission, and no less than quarterly or with a significant change. The charge nurse implements appropriate immediate interventions to prevent falls. The IDT team reviews falls in the morning clinical meeting Monday-Friday (excluding holidays) to ensure appropriate interventions have been implemented.Those residents at risk are reviewed by the IDT for the least restrictive device to prevent injury. The residents plan of care and C.N.A. assignment sheets are revised as appropriate.The DNS is responsible for monitoring the program. 4. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The DNS/Designee will complete the Falls/Falls Prevention CQI tool weekly for 4 weeks and monthly for 6 months and report findings to the CQI Committee. The CQI committee will review the CQI tools and if thresholds of 90% is not met, action plans will be developed to improve performance and determine the need for further	

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	155165	A. BUILDING 00 B. WING	10/07/2011

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	picking non-existent things off the floor. They stated res. has a "black spot" on R eye & sees floaters & has always done. Also discusses sleep pattern disturbance with res. being awake and Up all noc (night) and drowsy during am..." 2/17/11 "IDT for fall review. On 2/17 at 10:05 pm Rd (res) abed (in bed). Staff heard alarm sounding. Staff responded immediately. Rd noted on floor lying on back full body assessed and noted a lg (large) contusion on back of head...Intervention. also in place is PAB/PAC (Personal alarm bed/chair); convex mattress, toilet q. 2 hrs, hourly cks,..." 3/24/11 "IDT review for fall 3/23/11 @ 10:30 pm. Res was in bed, got up was found on knees next to bed holding on to side rail. Alarm was sounding. Res. incont. @ x (time) of fall...New intervention (cont.) gripper socks while abed." 4/11/11 "IDT review for fall on 4/9/11 @ 11:20 a.m...Res. got self up OOB & slid to floor, was found sitting on buttocks...Res. was incontinent @ x of fall. Alarm on bed sounded, staff responded. New intervention to check q. hr while abed."		action.Non-Compliance with facility procedures may result in re-education and/or disciplinary action.	

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	4/12/11 "IDT for fall review. Res had un-witnessed fall on 4/11/11 at 8:30 p.m., in hall. Prior to fall res was sitting in G-chair (a reclining chair). Res was noticed by staff to be lying on floor next to chair. He was lying on (L) (left) side with (L) hand resting under (L) side head. Res was fully clothed. Res. incontinent of bowel at time of fall. Res stated " I hit my head."...Abrasion/bruising noted to (L) side forehead. Skin tear top (L) hand...Intervention staff to toilet after meals." 4/18/11"IDT for fall review. On 4/16/11 at 11 a.m., unassisted fall. Nurse witnessed Rd attempting to get out of G-chair by self by scooting to edge of chair & stood up& fell forward onto left side...Will continue interventions: Scoop mattress, PAB & PAC...Will try and transfer to standard chair for meals & sit with staff or family member at meals..." 5/26/11 "IDT for fall review on 5/25/11 @ 8:30 pm. Res. was found lying on floor next to bed on (L) side. ROM (range of motion) WNL (within normal limits) x 4. Res. noted with small abrasion to top of head...New intervention is mat bedside (sic) bed R/T res. rolling out of bed." Review of the Interim/Admission Nursing			

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	Care Plan, dated 2/14/11, included, but was not limited to: "Problem: Fall Risk related to: impaired balance Goal: Resident will have no injury related to falls. Interventions: checked were Observe for fall risk contributors such as medications, hypotension, pain, unsteady gait., Encourage and remind resident to use call light, Refer to therapies for screening, Provide assistance for transfers, bed mobility, Fall risk assessment, Provide appropriate assistive devices such as walker, low bed, mats on floor, alarms or chairs/bed." On 10/06/2011 at 9:20 a.m., in interview with the Director of Nursing, she indicated there was no documentation to support hourly checks and toileting was being done as care planned. The facility failed to implement a low bed after being made aware by family of the resident getting out of bed during the night. 3.1-45(a)(2)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on record review, observation and interview the facility failed to ensure the handwashing procedure and the infection control policy had been followed to prevent cross contamination from resident	F0441	It is the practice of this provider to estabilish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent	11/01/2011

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	to resident. This deficient practice affected 3 of 49 residents observed during lunchtime dining. (Resident # 075) (Resident # 076) (Resident # 026) Findings include: Observation during lunch on 10/03/2011 between 11:40 a.m. and 12:15 p.m., Speech Therapist (ST) #1 was sitting at the table of Resident #026 with her supplies which included; but not limited to, clip board and sipper cup that were placed on the table next to Resident #026. Resident #076, who was sitting at another table, dropped his glass of tomato juice on the floor. ST #1 went over to Resident #076 and picked his cup up off the floor and set it back on the table and then went to the kitchen window to get a new cup of tomato juice for the resident. ST #1 gave the tomato juice to Resident #076 and then went back to the table of Resident #026 and picked up her supplies that were on the table which included; but was not limited to, a clip board and a sipper cup. ST #1 proceeded with her supplies to the table of Resident #075 to evaluate the resident for drinking and eating. ST #1 put fluids into the sipper cup and handed Resident #075 silverware. Resident #075 dropped his hat off of his head onto the floor. ST #1 got up and went around and picked the hat up off of the floor and put		the development and transmission of disease and infection. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The DNS evaluated residents #26, #76, and #75 to determine if actions of ST#1 resulted in adverse reaction of these residents. No negative outcomes were identified.On 10/3/11 ST#1 received 1:1 in-service education on proper infection control practices, specifically related to handwashing during meal service. The in-service was conducted by the Staff Development Coordinator.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Residents who attend the main dining room for meal service have the potential to be affected by this practice. Resident's who participate in the main didning room program were interviewed by dining service team on 10/4/11 and no other residents were identified.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?An in-service will be conducted by the Infection Control Nurse with staff who deliver food on proper Infection Control Procedures specifically related to handwashing during	

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	it back on Resident #075 head. She then flipped her hair back and walked back to sit down and then touched Resident #075's straw to stir the resident's drink. ST #1 sat for approximately 30 minutes and during that time she repeatedly touched her hair, face and ear, while continuing to touch Resident #075 utensils and cups. ST #1 did not wash her hands or use alcohol gel at anytime during the observation. In an interview on 10/03/2011 at 2:15 p.m., with the Administrator at the end of day exit conference, when discussing the observation of ST #1 the Administrator indicated an in- service would be done that day with ST # 1 as her not washing hands or alcohol gel was not an acceptable practice. On 10/07/2011 at 10:00 a.m., review of the facility's policy on handwashing included; but was not limited to, "Health Care Workers shall wash hands: 1. .....handling hair, etc..... 2. Before/after preparing/serving meals, drinks..... 3. Before/after having direct physical contact with residents." At this time, review of the facility's infection control update included; but was not limited to, "The purpose of handwashing is to get rid of dirt and		meal service.During meal service the dining room will be monitored by a designated staff member to ensure proper infection control practices are being followed.4. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place?The DNS and or Designee will complete the Meal Service Observation CQI tool weekly for 4 weeks and monthly for 6 months and report findings to the CQI Committee. The CQI committee will review the CQI tools and if thresholds of 90% are not met , action plans will be developed to improve performance and determine the need for further action.Non-Compliance with facility procedures may result in re-education and/or disciplinary action.	

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	"transient" germs." "Standard precautions apply to all your clients, no matter what their diagnosis-even if they don't seem sick!" Review of ST #1 orientation dated 03/31/2011 - 04/01/2011 under "Safety" included; but was not limited to, "department specific infection control". Under the facility's lesson plan, key points and teaching strategies included; but were not limited to, "B. Methods of Compliance 1. Universal precautions. 2. Workplace Controls b. Handwashing." These were signed off as completed. 3.1-18(1)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure a room change notice was maintained in the clinical record for Resident #2 and failed to	F0514	It is the practice of this provider to maintain clinical records on each resident in accordance wiht accepted professional standards and practicies that are complete	11/01/2011

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	ensure the list of medication allergies was correct for Resident #076. This practice affected 2 of 23 residents reviewed for complete and accurate documentation in the sample of 23. Findings include: 1. Review of the clinical record for Resident #2 on 10/4/2011 at 4:30 p.m., indicated the resident was admitted to the facility on 5/13/2011 and had diagnoses which included, but were not limited to: muscle weakness and dementia with behavior disturbance. On 6/23/2011, Resident #2 moved from Room 163-A to Room 157-B due to needing a more compatible roommate. Documentation was lacking of a "Intra-Facility Transfer Notice of Room Change" having been completed. On 10/6/2011 at 1:35 p.m., Social Worker #1 presented a copy of the 6/23/2011 room change notice. She indicated it had gotten lost in a pile of papers on her desk.		accurately documented; readily accessible; and systematically organized.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?On 10/5/11 the Physician was notified regarding the descrepancy allergy listing on his dictated History and Physical dated 2/17/11. The physician revised the allergies on his dictated History and Physical indicating the resident did not have an allergy to Risperdone on 10/5/11.Resident #2 Intra facility transfer form was located in the Social Service Office and was placed on chart.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?All residents have the potential to be affected by this practice. An audit of the clinical record for allergies was conducted by medical records upon admission/re-admission, and no less than quarterly and/or with a significant change. Residents requiring intra facility transfers have the potential to be affected by this practice.An audit was conducted of intra facility transfers to ensure proper completion of the Intra Faciliy Transfer Notice of Room Change. No other concerns were identified. 3. What measures will be put into place or what systemic changes will be made to ensure	

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			that the deficient practice does not recur?The Clinical Record Admission Audit and the Quarterly On-Going Audit will be revised to include the listed allergies are accurate. The Medical Records Coordinator will be responsible for conducting the audit.An electonic report will be reviewed weekly to ensure proper notification/completion of the Intra Facility Transfer Notice of Room Change is completed timely and in the clinical record by the SSD.The Medical Records Coordinator will audit all new admissions, readmissions, no less than quarterly and/or significant change.4. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place?The DNS/Designee will complete the Medical Records CQI tool weekly for 4 weeks and monthly for 6 months and report findings to the CQI Committee. The CQI committee will review the CQI tools and if thresholds of 90% are not met , action plans will be developed to improve performance and determine the need for further action.The ED/Designee will complete the Social Services CQI tool weekly for 4 weeks and monthly for 6 months and report findings to the CQI Committee. The CQI Committee will review the CQI tools and if thresholds 90% are not met, action plans will	

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			be developed to improve performance and determine the need for further action.Non-Compliance with facility procedures may result in re-education and/or disciplinary action.	

2. The clinical record for Resident #076 was reviewed on 10/05/2011 at 11 a.m. The resident was admitted to the facility on 2/14/11. The Physician's Orders, dated 2/14/11, indicated the resident had allergies to Clozapine (to treat acute manic episodes of bipolar disorder), Quetiapine (to treat Schizophrenia), and Seroquel (to treat Schizophrenia). The History & Physical, dated 02/17/2011, included, but was not limited to "Allergies: Seroquel and Risperdal (to treat Schizophrenia)." Progress Notes, dated 3/20/2011, 5/4/2011 and 6/8/2011 indicated "Allergies: Seroquel and Risperdal."

On 10/05/11 at 11:30 a.m., in interview with the Director of Nursing, she was not aware of the discrepancy. On 10/06/2011 at 8 a.m., a faxed note sent on 10/05/2011 at 1:23 p.m., was returned to the facility with the February 17, 2011 History and Physical which had "error" next to Risperdal and signed by the attending MD. The note faxed to the MD indicated "Please note Resident allergies are the following Clozapine & Quefiapine and

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	Seroquel Please see attached H & P. Could you please write a note next to allergies stating error and write true allergies initial and date and fax back ASAP (As soon as possible)." On 10/07/2011 at 12 p.m., the Psychiatric Progress Notes, dated 02/17/11, indicated the resident was currently receiving Risperdone 1.5 mg (milligram) q. (every) hs (night) and 1 mg (milligram) q. AM. 3.1-50(a)(1) 3.1-50(a)(3)			
F0518 SS=D	The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on observation, record review and interview, the facility failed to ensure laundry personnel were trained on how to turn off the gas valve to the dryers in an emergency for 2 of 2 laundry employees interviewed. (Laundry Employee #1, Laundry supervisor 1) Findings include: On 10/06/11 at 9:35 a.m., Laundry Employee #1 was observed folding clothes near the dryers. In interview, at	F0518	It is the policy of this provider to train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?On 10/6/11 The laundry aide and the laundry supervisor received education regarding the gas shut off valve in the laundry by the Maintenance	11/01/2011

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	this time, the employee was queried, if there were a fire in the dryer, what would you do? She indicated the dryers were gas and was not aware of how to turn off the gas as she had not been trained. The employee's hire date was listed as 11/30/99 on the Employee Record Form provided by the facility on 10/03/11. On 10/06/11 at 9:43 a.m., the Laundry Supervisor was queried as to how to turn off the gas in an emergency. She indicated she would ask maintenance as she was not aware and had not been trained. The employee's hire date was listed as 11/30/99 on the Employee Record Form. On 10/06/11 at 9:47 a.m., Maintenance personnel came to the laundry and indicated each dryer had a blue knob on the gas pipe to shut off the gas. 3.1-51(b)		Director.2. How will the facility identify other residents having the potential to be affected by the same deficient practice will be indentified and what corrective action(s) will be taken?No residents were identified as being affected by this practice.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?Current employees will be educated on or before 11/01/11 regarding the location of the gas shut off valves in the laundry by the Executive Director and or Designee.Upon hire to the facility the SDC will orientate new hires on the location of the gas shut off valve. 4. How will the corrective action be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place? The Housekeeping/Laundry Director will conduct the Environmental Safety CQI tool weekly for 4 weeks and monthly for 6 months and report findings to the CQI Committee. The CQI committee will review the CQI tools and if thresholds of 90% are not met, action plans will be developed to improve performance and determine the need for further action.Non-Compliance with facility procedures may result in re-education and/or disciplinary action.	